

**Return of Organization Exempt From Income Tax**  
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

Department of the Treasury  
Internal Revenue Service

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

**A For the 2011 calendar year, or tax year beginning , 2011, and ending , 20**

<b>B</b> Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization UPPER CHESAPEAKE MEDICAL CENTER			<b>D</b> Employer identification number 52-1253920	
	Doing Business As			<b>E</b> Telephone number (410) 877-3700	
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 500 UPPER CHESAPEAKE DRIVE		<b>G</b> Gross receipts \$ 241,216,767.		
	City or town, state or country, and ZIP + 4 BEL AIR, MD 21014			<b>H(a)</b> Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
<b>F</b> Name and address of principal officer: LYLE E SHELDON 520 UPPER CHESAPEAKE DR, STE 405, BEL AIR, MD 21014			<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
<b>J</b> Website: ▶ WWW.UCHS.ORG			<b>H(c)</b> Group exemption number ▶		
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			<b>L</b> Year of formation: 1997 <b>M</b> State of legal domicile: MD		

**Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: ACUTE HOSPITAL CARE		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	16.
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	12.
	<b>5</b> Total number of individuals employed in calendar year 2011 (Part V, line 2a)	<b>5</b>	2,242.
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	704.
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	0
<b>b</b> Net unrelated business taxable income from Form 990-T, line 34	<b>7b</b>	0	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	<b>9</b> Program service revenue (Part VIII, line 2g)	27,538,437.	7,361,725.
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	201,719,717.	229,956,458.
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	102,580.	579,927.
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	169,420.	275,563.
		229,530,154.	238,173,673.
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	11,364,025.	8,141,614.
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	89,163,616.	95,049,836.
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	101,925,468.	116,218,745.
<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	202,453,109.	219,410,195.	
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	27,077,045.	18,763,478.	
<b>Net Assets or Fund Balances</b>	<b>20</b> Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	<b>21</b> Total liabilities (Part X, line 26)	300,806,783.	321,262,781.
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	213,904,536.	234,530,464.
	86,902,247.	86,732,317.	

**Part II Signature Block**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

<b>Sign Here</b>	▶ Signature of officer		Date		
	▶ Type or print name and title				
<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN P00288383
	Firm's name ▶ GRANT THORNTON LLP			Firm's EIN ▶ 36-6055558	
	Firm's address ▶ 2001 MARKET STREET, SUITE 3100 PHILADELPHIA, PA 19103			Phone no. 215-561-4200	
May the IRS discuss this return with the preparer shown above? (see instructions) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					

For Paperwork Reduction Act Notice, see the separate instructions.

**Part III Statement of Program Service Accomplishments**

Check if Schedule O contains a response to any question in this Part III  Yes  No

1 Briefly describe the organization's mission:

ACUTE HOSPITAL CARE

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?  Yes  No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services?  Yes  No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: ) (Expenses \$ 160,339,944. including grants of \$ 8,080,501. ) (Revenue \$ 229,956,458. )

SEE SCHEDULE O

4b (Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )

4c (Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )

4d Other program services (Describe in Schedule O.)

(Expenses \$ including grants of \$ ) (Revenue \$ )

4e Total program service expenses 160,339,944.

**Part IV Checklist of Required Schedules**

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A . . . . .	X	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? . . . . .	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I . . . . .		X
4 <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II . . . . .	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III . . . . .		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I . . . . .		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II . . . . .		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III . . . . .		X
9 Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV . . . . .		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V . . . . .		X
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI . . . . .	X	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII . . . . .		X
c Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII . . . . .		X
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX . . . . .	X	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X . . . . .	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X . . . . .	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII . . . . .		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional . . . . .	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E . . . . .		X
14a Did the organization maintain an office, employees, or agents outside of the United States? . . . . .		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV . . . . .		X
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? If "Yes," complete Schedule F, Parts II and IV . . . . .		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? If "Yes," complete Schedule F, Parts III and IV . . . . .		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) . . . . .		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II . . . . .		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III . . . . .		X
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H . . . . .	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	X	

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, and Yes/No checkboxes. Rows include questions 21 through 38 regarding grants, compensation, tax-exempt bonds, excess benefit transactions, and controlled entities.

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding IRS filings and tax compliance.

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

Check if Schedule O contains a response to any question in this Part VI. [X]

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include questions 1a, 1b, 2, 3, 4, 5, 6, 7a, 7b, 8, 8a, 8b, 9.

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

Table with 3 columns: Question, Yes, No. Rows include questions 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: JOSEPH E. HOFFMAN, III 520 UPPER CHESAPEAKE DRIVE, BEL AIR, MD 21014 443-643-3340

**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Check if Schedule O contains a response to any question in this Part VII

**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) H. WILLIAM ACKER VICE CHAIRMAN/DIRECTOR	5.00	X	X				0	0	0	
(2) STEVEN M. BENTMAN, MD DIRECTOR	1.00	X					27,083.	0	0	
(3) JOHN H. CAIN DIRECTOR	1.00	X					0	0	0	
(4) MELINDA L. CRAIG DIRECTOR	1.00	X					0	0	0	
(5) DIANE K. FORD DIRECTOR	1.00	X					0	0	0	
(6) ROBERT F. HOOFNAGLE, JR., MD DIRECTOR	1.00	X					65,792.	0	0	
(7) M. SCOT KAUFMAN SECRETARY/DIRECTOR	5.00	X	X				0	0	0	
(8) ANDREW KLEIN DIRECTOR	1.00	X					0	0	0	
(9) JAMES LAMBDIN DIRECTOR	1.00	X					0	0	0	
(10) ANTHONY J. MEOLI TREASURER/DIRECTOR	5.00	X	X				0	0	0	
(11) ROGER E. SCHNEIDER, MD CHAIRMAN/DIRECTOR	5.00	X	X				0	0	0	
(12) LYLE E. SHELDON PRESIDENT & CEO/DIRECTOR	5.00	X	X				0	802,498.	90,419.	
(13) RICHARD P. STREETT, JR., VMD DIRECTOR	1.00	X					0	0	0	
(14) ADELE A. WILZACK, RN, MS DIRECTOR	1.00	X					0	0	0	

**Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** (continued)

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 15) ALBERT J. A. YOUNG DIRECTOR	1.00	X					0	0	0	
( 16) FAHEEM YOUNUS, MD DIRECTOR	1.00	X					151,250.	0	0	
( 17) JOYCE FOX VP - PATIENT SVCS/CNO	20.00				X		0	223,146.	44,446.	
( 18) JOSEPH E. HOFFMAN III SR VP/CFO	5.00				X		0	396,292.	81,484.	
( 19) KENNETH D. KOZEL SR VP/COO	5.00				X		0	394,262.	63,239.	
( 20) DEAN C. KASTER SR VP - CORP STRATEGY/PLANNING	5.00				X		0	276,903.	58,880.	
( 21) MARGARET M. VAUGHAN SR VP - CHIEF MEDICAL OFFICER	5.00				X		0	376,634.	77,548.	
( 22) E. SCOTT CONOVER SR VP/GENERAL COUNSEL	5.00				X		0	354,257.	52,953.	
( 23) TONI M. SHIVERY VP - HUMAN RESOURCES	5.00				X		0	200,181.	64,160.	
( 24) ROY PHILLIPS PHYSICIAN/HOSPITALIST	40.00					X	255,803.	0	46,478.	
( 25) OLUFUNMILAYO ONOBRAKPEYA PHYSICIAN	40.00					X	223,702.	0	20,775.	
<b>1b Sub-total</b> .....							92,875.	802,498.	90,419.	
<b>c Total from continuation sheets to Part VII, Section A</b> .....							1,050,117.	2,221,675.	628,636.	
<b>d Total (add lines 1b and 1c)</b> .....							1,142,992.	3,024,173.	719,055.	

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 78

	Yes	No
3 Did the organization list any <b>former</b> officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> .....		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i> .....	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> .....		X

**Section B. Independent Contractors**

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 26



**Part VIII Statement of Revenue**

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>					
	<b>b</b> Membership dues . . . . .	<b>1b</b>					
	<b>c</b> Fundraising events . . . . .	<b>1c</b>					
	<b>d</b> Related organizations . . . . .	<b>1d</b>	7,361,725.				
	<b>e</b> Government grants (contributions) . .	<b>1e</b>					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above .	<b>1f</b>					
	<b>g</b> Noncash contributions included in lines 1a-1f: \$						
	<b>h Total.</b> Add lines 1a-1f . . . . .			7,361,725.			
<b>Program Service Revenue</b>		<b>Business Code</b>					
	<b>2a</b> NET PATIENT SERVICE REVENUE		621110	229,797,797.	229,797,797.		
	<b>b</b> SPINE CENTER/ENDOCRINOLOGY		621110	158,661.	158,661.		
	<b>c</b>						
	<b>d</b>						
	<b>e</b>						
	<b>f</b> All other program service revenue . . . . .						
	<b>g Total.</b> Add lines 2a-2f . . . . .			229,956,458.			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			163,688.			163,688.
	<b>4</b> Income from investment of tax-exempt bond proceeds . . .			0			
	<b>5</b> Royalties . . . . .			0			
		(i) Real	(ii) Personal				
	<b>6a</b> Gross rents . . . . .	1,410,089.					
	<b>b</b> Less: rental expenses . . . . .	3,043,094.					
	<b>c</b> Rental income or (loss) . . . . .	-1,633,005.					
	<b>d</b> Net rental income or (loss) . . . . .			-1,633,005.			-1,633,005.
		(i) Securities	(ii) Other				
	<b>7a</b> Gross amount from sales of assets other than inventory	516,669.	-100,430.				
	<b>b</b> Less: cost or other basis and sales expenses . . . . .						
	<b>c</b> Gain or (loss) . . . . .	516,669.	-100,430.				
	<b>d</b> Net gain or (loss) . . . . .			416,239.			416,239.
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . .	<b>a</b>					
	<b>b</b> Less: direct expenses . . . . .	<b>b</b>					
<b>c</b> Net income or (loss) from fundraising events . . . . .			0				
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .	<b>a</b>						
<b>b</b> Less: direct expenses . . . . .	<b>b</b>						
<b>c</b> Net income or (loss) from gaming activities . . . . .			0				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>						
<b>b</b> Less: cost of goods sold . . . . .	<b>b</b>						
<b>c</b> Net income or (loss) from sales of inventory . . . . .			0				
Miscellaneous Revenue			<b>Business Code</b>				
<b>11a</b> CAFETERIA SALES		900099	1,093,279.			1,093,279.	
<b>b</b> PARKING GARAGE		900099	202,776.			202,776.	
<b>c</b> LOSS ON EARLY RETIREMENT OF DEBT		900099	-111,896.			-111,896.	
<b>d</b> All other revenue . . . . .		900099	724,409.			724,409.	
<b>e Total.</b> Add lines 11a-11d . . . . .			1,908,568.				
<b>12 Total revenue.</b> See instructions . . . . .			238,173,673.	229,956,458.		855,490.	

**Part IX Statement of Functional Expenses**

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Check if Schedule O contains a response to any question in this Part IX  X

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 . . . . .	8,141,614.	8,141,614.		
2 Grants and other assistance to individuals in the United States. See Part IV, line 22 . . . . .	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16 . . . . .	0			
4 Benefits paid to or for members . . . . .	0			
5 Compensation of current officers, directors, trustees, and key employees . . . . .	0			
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	0			
7 Other salaries and wages . . . . .	77,302,959.	57,044,270.	20,258,689.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	4,673,489.	3,448,714.	1,224,775.	
9 Other employee benefits . . . . .	6,351,206.	4,670,738.	1,680,468.	
10 Payroll taxes . . . . .	6,722,182.	4,960,508.	1,761,674.	
11 Fees for services (non-employees):				
a Management . . . . .	0			
b Legal . . . . .	0			
c Accounting . . . . .	22,310.		22,310.	
d Lobbying . . . . .	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees . . . . .	0			
g Other . . . . .	6,835,233.	4,219,507.	2,615,726.	
12 Advertising and promotion . . . . .	836,475.	816.	835,659.	
13 Office expenses . . . . .	51,100,242.	46,834,132.	4,266,110.	
14 Information technology . . . . .	0			
15 Royalties . . . . .	0			
16 Occupancy . . . . .	2,767,510.		2,767,510.	
17 Travel . . . . .	27,197.	14,513.	12,684.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings . . . . .	108,449.	7,262.	101,187.	
20 Interest . . . . .	2,968,185.	1,877,154.	1,091,031.	
21 Payments to affiliates . . . . .	0			
22 Depreciation, depletion, and amortization . . . . .	8,957,545.	6,456,381.	2,501,164.	
23 Insurance . . . . .	2,793,535.	2,061,437.	732,098.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <u>PROVISION FOR BAD DEBT</u> . . . . .	13,889,579.	13,889,579.		
b <u>MANAGEMENT FEES - UCHS</u> . . . . .	7,345,781.		7,345,781.	
c <u>PURCHASED SERVICES</u> . . . . .	4,437,627.	2,239,476.	2,198,151.	
d <u>MAINTENANCE CONTRACT</u> . . . . .	2,626,122.	741,092.	1,885,030.	
e All other expenses . . . . .	11,502,955.	3,732,751.	7,770,204.	
25 <b>Total functional expenses.</b> Add lines 1 through 24e	219,410,195.	160,339,944.	59,070,251.	
26 <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) . . . . .	0			

**Part X Balance Sheet**

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing . . . . .	20,493,286.	<b>1</b>	18,019,127.
	<b>2</b> Savings and temporary cash investments . . . . .	0	<b>2</b>	0
	<b>3</b> Pledges and grants receivable, net . . . . .	0	<b>3</b>	0
	<b>4</b> Accounts receivable, net . . . . .	21,238,343.	<b>4</b>	26,206,766.
	<b>5</b> Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .	0	<b>5</b>	0
	<b>6</b> Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) . . . . .	0	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use . . . . .	4,325,056.	<b>8</b>	5,693,980.
	<b>9</b> Prepaid expenses and deferred charges . . . . .	444,953.	<b>9</b>	1,214,175.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 232,547,673.		
	<b>b</b> Less: accumulated depreciation . . . . .	<b>10b</b> 76,761,675.	146,439,423.	<b>10c</b> 155,785,998.
	<b>11</b> Investments - publicly traded securities . . . . .	53,944,023.	<b>11</b>	41,080,170.
	<b>12</b> Investments - other securities. See Part IV, line 11 . . . . .	0	<b>12</b>	0
	<b>13</b> Investments - program-related. See Part IV, line 11 . . . . .	0	<b>13</b>	0
	<b>14</b> Intangible assets . . . . .	543,168.	<b>14</b>	383,343.
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	53,378,531.	<b>15</b>	72,879,222.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	300,806,783.	<b>16</b>	321,262,781.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	21,364,795.	<b>17</b>	24,574,005.
	<b>18</b> Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b> Deferred revenue . . . . .	0	<b>19</b>	0
	<b>20</b> Tax-exempt bond liabilities . . . . .	147,235,698.	<b>20</b>	146,396,066.
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .	0	<b>21</b>	0
	<b>22</b> Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .	0	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	0	<b>23</b>	0
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D . . . . .	45,304,043.	<b>25</b>	63,560,393.	
<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	213,904,536.	<b>26</b>	234,530,464.	
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117, check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets . . . . .	86,902,247.	<b>27</b>	79,725,317.
	<b>28</b> Temporarily restricted net assets . . . . .	0	<b>28</b>	7,007,000.
	<b>29</b> Permanently restricted net assets . . . . .	0	<b>29</b>	0
	<b>Organizations that do not follow SFAS 117, check here</b> <input type="checkbox"/> <b>and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds . . . . .		<b>32</b>	
<b>33</b> Total net assets or fund balances . . . . .	86,902,247.	<b>33</b>	86,732,317.	
<b>34</b> Total liabilities and net assets/fund balances . . . . .	300,806,783.	<b>34</b>	321,262,781.	

**Part XI Reconciliation of Net Assets**

Check if Schedule O contains a response to any question in this Part XI

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12) . . . . .	<b>1</b>	238,173,673.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25) . . . . .	<b>2</b>	219,410,195.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1 . . . . .	<b>3</b>	18,763,478.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . . . . .	<b>4</b>	86,902,247.
<b>5</b>	Other changes in net assets or fund balances (explain in Schedule O) . . . . .	<b>5</b>	-18,933,408.
<b>6</b>	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B)) . . . . .	<b>6</b>	86,732,317.

**Part XII Financial Statements and Reporting**

Check if Schedule O contains a response to any question in this Part XII

		Yes	No
<b>1</b>	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
<b>2a</b>	Were the organization's financial statements compiled or reviewed by an independent accountant? . . . . .		X
<b>2b</b>	Were the organization's financial statements audited by an independent accountant? . . . . .	X	
<b>2c</b>	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? . . . . . If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
<b>d</b>	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		
<b>3a</b>	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? . . . . .		X
<b>3b</b>	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

**SCHEDULE A**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

**2011**

**Open to Public Inspection**

<b>Name of the organization</b> UPPER CHESAPEAKE MEDICAL CENTER	<b>Employer identification number</b> 52-1253920
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**Part I Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2  A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8  A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9  An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)

- 10  An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3)**. Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a  Type I      b  Type II      c  Type III - Functionally integrated      d  Type III - Other

e  By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box.

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

- (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? .....
- (ii) A family member of a person described in (i) above? .....
- (iii) A 35% controlled entity of a person described in (i) or (ii) above? .....

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
<b>Total</b>									

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule A (Form 990 or 990-EZ) 2011

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Table with 7 columns: (a) 2007, (b) 2008, (c) 2009, (d) 2010, (e) 2011, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2007, (b) 2008, (c) 2009, (d) 2010, (e) 2011, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Percentage, %. Rows include: 14 Public support percentage for 2011; 15 Public support percentage from 2010 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2011; b 33 1/3% support test - 2010; 17a 10%-facts-and-circumstances test - 2011; b 10%-facts-and-circumstances test - 2010; 18 Private foundation.

**Part III Support Schedule for Organizations Described in Section 509(a)(2)**  
 (Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II.  
 If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose . . . . .						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf . . . . .						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge . . . . .						
<b>6 Total.</b> Add lines 1 through 5 . . . . .						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons . . . . .						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year . . . . .						
<b>c</b> Add lines 7a and 7b. . . . .						
<b>8 Public support</b> (Subtract line 7c from line 6.) . . . . .						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>9</b> Amounts from line 6. . . . .						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . . .						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 . . . . .						
<b>c</b> Add lines 10a and 10b . . . . .						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on . . . . .						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) . . . . .						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.) . . . . .						

**14 First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** . . . . .

**Section C. Computation of Public Support Percentage**

<b>15</b> Public support percentage for 2011 (line 8, column (f) divided by line 13, column (f)). . . . .	<b>15</b>	%
<b>16</b> Public support percentage from 2010 Schedule A, Part III, line 15 . . . . .	<b>16</b>	%

**Section D. Computation of Investment Income Percentage**

<b>17</b> Investment income percentage for <b>2011</b> (line 10c, column (f) divided by line 13, column (f)) . . . . .	<b>17</b>	%
<b>18</b> Investment income percentage from <b>2010</b> Schedule A, Part III, line 17 . . . . .	<b>18</b>	%

**19a 33 1/3% support tests - 2011.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

**b 33 1/3% support tests - 2010.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

**20 Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ►

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**Part IV** **Supplemental Information.** Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

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**Schedule of Contributors**

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.

**2011**

<b>Name of the organization</b> UPPER CHESAPEAKE MEDICAL CENTER	<b>Employer identification number</b> 52-1253920
--	---

**Organization type** (check one):

**Filers of:**

**Section:**

Form 990 or 990-EZ

501(c)(3) ( ) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

**Note.** Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

**General Rule**

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

**Special Rules**

For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of \$5,000 or more during the year . . . . . ▶ \$ \_\_\_\_\_

**Caution.** An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on Part I, line 2, of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

<b>Name of organization</b> UPPER CHESAPEAKE MEDICAL CENTER	<b>Employer identification number</b> 52-1253920
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	\$ 7,350,216.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

**Part II** Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number  
52-1253920

**Part III** *Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year.* Complete columns (a) through (e) and the following line entry.

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ► \$ \_\_\_\_\_

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	

**SCHEDULE C**  
(Form 990 or 990-EZ)

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

**2011**

**Open to Public Inspection**

**For Organizations Exempt From Income Tax Under section 501(c) and section 527**

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**

▶ **See separate instructions.**

Department of the Treasury  
Internal Revenue Service

**If the organization answered "Yes" to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then**

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

**If the organization answered "Yes" to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then**

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

**If the organization answered "Yes" to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then**

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
- 2 Political expenditures . . . . . ▶ \$ \_\_\_\_\_
- 3 Volunteer hours . . . . . \_\_\_\_\_

**Part I-B Complete if the organization is exempt under section 501(c)(3).**

- 1 Enter the amount of any excise tax incurred by the organization under section 4955. . . . . ▶ \$ \_\_\_\_\_
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 . . . . . ▶ \$ \_\_\_\_\_
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? . . . . .  Yes  No
- 4a Was a correction made? . . . . .  Yes  No  
b If "Yes," describe in Part IV.

**Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).**

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities . . . . . ▶ \$ \_\_\_\_\_
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities . . . . . ▶ \$ \_\_\_\_\_
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b . . . . . ▶ \$ \_\_\_\_\_
- 4 Did the filing organization file **Form 1120-POL** for this year? . . . . .  Yes  No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
(1)	-----			
(2)	-----			
(3)	-----			
(4)	-----			
(5)	-----			
(6)	-----			

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule C (Form 990 or 990-EZ) 2011

**Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

- A** Check  if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B** Check  if the filing organization checked box A and "limited control" provisions apply.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
<b>1 a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) . . . . .														
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) . . . . .														
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) . . . . .														
<b>d</b> Other exempt purpose expenditures . . . . .														
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) . . . . .														
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 70%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
Not over \$500,000	20% of the amount on line 1e.													
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.													
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.													
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.													
Over \$17,000,000	\$1,000,000.													
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) . . . . .														
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- . . . . .														
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- . . . . .														
<b>j</b> If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No												

**4-Year Averaging Period Under Section 501(h)**  
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

<b>Lobbying Expenditures During 4-Year Averaging Period</b>					
Calendar year (or fiscal year beginning in)	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) Total
<b>2 a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column (e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

Table with 3 columns: Question, Yes, No. Rows include: 1 Were substantially all (90% or more) dues received nondeductible by members?; 2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?; 3 Did the organization agree to carry over lobbying and political expenditures from the prior year?

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

Table with 3 columns: Question, Yes, No. Rows include: 1 Dues, assessments and similar amounts from members; 2 Section 162(e) nondeductible lobbying and political expenditures; 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues; 4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?; 5 Taxable amount of lobbying and political expenditures (see instructions).

Part IV Supplemental Information

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A; and Part II-B, line 1. Also, complete this part for any additional information. LOBBYING ACTIVITIES SCHEDULE C, PART II-B, LINE 1I LOBBYING EXPENSES IN THE AMOUNT OF \$22,524 FOR 12/31/11 REPRESENT A PORTION OF THE DUES PAID TO AMERICAN HOSPITAL ASSOCIATION AND MARYLAND HOSPITAL ASSOCIATION. THESE ASSOCIATIONS ALLOCATE A PORTION OF MEMBER DUES TO LOBBYING ACTIVITY.

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**Part IV** Supplemental Information *(continued)*

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SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2011

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. Attach to Form 990. See separate instructions.

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

Table with 3 columns: Line number, Description, (a) Donor advised funds, (b) Funds and other accounts. Includes rows for total number at end of year, aggregate contributions, aggregate grants, aggregate value, and two Yes/No questions regarding donor advisement.

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

Table with 3 columns: Line number, Description, Held at the End of the Tax Year. Includes rows for purpose(s) of conservation easements, total number of easements, total acreage, and various monitoring and reporting questions.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

Table with 3 columns: Line number, Description, Amount. Includes rows for reporting on collections of art, historical treasures, and other similar assets, including revenues and assets.

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule D (Form 990) 2011

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

- a Public exhibition, b Scholarly research, c Preservation for future generations, d Loan or exchange programs, e Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

b If "Yes," explain the arrangement in Part XIV and complete the following table:

Table with 2 columns: Description, Amount. Rows: 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance.

2a Did the organization include an amount on Form 990, Part X, line 21?

b If "Yes," explain the arrangement in Part XIV.

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows: 1a-1g (Beginning of year balance, Contributions, Net investment earnings, gains, and losses, Grants or scholarships, Other expenditures for facilities and programs, Administrative expenses, End of year balance).

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

- a Board designated or quasi-endowment %
b Permanent endowment %
c Temporarily restricted endowment %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

- (i) unrelated organizations
(ii) related organizations

Table with 2 columns: Yes, No. Rows: 3a(i), 3a(ii), 3b.

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

4 Describe in Part XIV the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Table with 5 columns: (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other, Total.

**Part VII Investments - Other Securities.** See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other _____		
(A) _____		
(B) _____		
(C) _____		
(D) _____		
(E) _____		
(F) _____		
(G) _____		
(H) _____		
(I) _____		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.)		

**Part VIII Investments - Program Related.** See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) _____		
(2) _____		
(3) _____		
(4) _____		
(5) _____		
(6) _____		
(7) _____		
(8) _____		
(9) _____		
(10) _____		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 13.)		

**Part IX Other Assets.** See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) OTHER ACCTS RECEIVABLE	42,255.
(2) DEFERRED FINANCING COSTS	1,128,390.
(3) DUE FROM AFFILIATES	58,890,413.
(4) FUNDS HELD BY TRUSTEE	3,419,077.
(5) ECON INT FOUNDATION NET ASSETS	7,007,000.
(6) CURRENT PORTION OF ASSETS LTD	2,392,087.
(7) _____	
(8) _____	
(9) _____	
(10) _____	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.)	72,879,222.

**Part X Other Liabilities.** See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES FROM THIRD PARTIES	5,064,661.
(3) ACCRUED PENSION LIABILITY	7,140,060.
(4) BOND INTEREST RATE SWAP	51,355,672.
(5) _____	
(6) _____	
(7) _____	
(8) _____	
(9) _____	
(10) _____	
(11) _____	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.)	63,560,393.

2. FIN 48 (ASC 740) Footnote. In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740).

**Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements**

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	238,173,673.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	219,410,195.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	18,763,478.
4	Net unrealized gains (losses) on investments	4	68,902.
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-19,003,599.
9	Total adjustments (net). Add lines 4 through 8	9	-18,934,697.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-171,219.

**Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return**

1	Total revenue, gains, and other support per audited financial statements	1	212,474,569.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	68,902.
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV.)	2d	-28,811,100.
e	Add lines 2a through 2d	2e	-28,742,198.
3	Subtract line 2e from line 1	3	241,216,767.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV.)	4b	-3,043,094.
c	Add lines 4a and 4b	4c	-3,043,094.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5	238,173,673.

**Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return**

1	Total expenses and losses per audited financial statements	1	212,645,788.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIV.)	2d	3,043,094.
e	Add lines 2a through 2d	2e	3,043,094.
3	Subtract line 2e from line 1	3	209,602,694.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV.)	4b	9,807,501.
c	Add lines 4a and 4b	4c	9,807,501.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5	219,410,195.

**Part XIV Supplemental Information**

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

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SEE PAGE 5

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**Part XIV** Supplemental Information (continued)

INCOME TAXES (FIN 48)

PART X, QUESTION 2

UPPER CHESAPEAKE MEDICAL CENTER ACCOUNTS FOR TAX PROVISIONS IN ACCORDANCE WITH FASB INTERPRETATION NO. 48 (FIN 48), ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES, INCLUDED IN ASC SUBTOPIC 740-10, INCOME TAXES - OVERALL, WHICH CLARIFIES THE ACCOUNTING FOR UNCERTAINTY IN TAX PROVISIONS. FIN 48 REQUIRES THAT UPPER CHESAPEAKE MEDICAL CENTER RECOGNIZE THE EFFECT OF INCOME TAX POSITIONS ONLY IF THOSE POSITIONS ARE MORE LIKELY THAN NOT OF BEING SUSTAINED. RECOGNIZED INCOME TAX POSITIONS ARE MEASURED AT THE LARGEST AMOUNT THAT IS GREATER THAN 50% LIKELY OF BEING REALIZED. CHANGES IN RECOGNITION OR MEASUREMENT ARE REFLECTED IN THE PERIOD IN WHICH THE CHANGE IN JUDGMENT OCCURS.

RECONCILIATION OF CHANGE IN NET ASSETS

SCHEDULE D, PART XI, LINE 8

UNREALIZED GAIN/(LOSS) ON SWAP	(12,174,354)
MINIMUM PENSION LIABILITY	(6,829,245)
	-----
TOTAL	(19,003,599)
	=====

**Part XIV** Supplemental Information (continued)

## RECONCILIATION OF REVENUE

## SCHEDULE D, PART XII

## LINE 2D - OTHER REVENUE ON BOOKS NOT ON RETURN

UNREALIZED GAIN/(LOSS) ON SWAP	\$(12,174,354)
MINIMUM PENSION LIABILITY	(6,829,245)
RECLASS - TRANSFER TO/FROM AFFILIATES	(9,807,501)
	-----
TOTAL	\$(28,811,100)
	=====

## LINE 4B - OTHER REVENUE ON RETURN NOT ON BOOKS

RECLASS - RENTAL EXPENSES	\$ (3,043,094)
---------------------------	----------------

## RECONCILIATION OF EXPENSES

## SCHEDULE D, PART XIII

## LINE 2D - OTHER EXPENSES INCLUDED ON BOOKS NOT ON RETURN

RECLASS - RENTAL EXPENSES	\$3,043,094
---------------------------	-------------

## LINE 4B - OTHER EXPENSES INCLUDED ON RETURN NOT ON BOOKS

RECLASS - TRANSFER TO/FROM AFFILIATES	\$9,807,501
---------------------------------------	-------------

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2011**

**Open to Public Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**  
▶ **Attach to Form 990. ▶ See separate instructions.**

Department of the Treasury  
Internal Revenue Service

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .	X	
<b>1b</b> If "Yes," was it a written policy? . . . . .	X	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: . . . . . <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
<b>b</b> Did the organization use FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . . <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
<b>c</b> If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . .	X	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
<b>5b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .		X
<b>5c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? . . . . .		
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	X	
<b>6b</b> If "Yes," did the organization make it available to the public? . . . . .	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

<b>7 Financial Assistance and Certain Other Community Benefits at Cost</b>						
<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a) Number of activities or programs (optional)</b>	<b>(b) Persons served (optional)</b>	<b>(c) Total community benefit expense</b>	<b>(d) Direct offsetting revenue</b>	<b>(e) Net community benefit expense</b>	<b>(f) Percent of total expense</b>
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			12,895,119.		12,895,119.	6.00
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .						
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			12,895,119.		12,895,119.	6.00
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			1,784,910.	73,345.	1,711,565.	1.00
<b>f</b> Health professions education (from Worksheet 5) . . . . .			81,571.		81,571.	.04
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			3,441,825.		3,441,825.	2.00
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			73,133.		73,133.	.03
<b>j Total.</b> Other Benefits . . . . .			5,381,439.	73,345.	5,308,094.	3.07
<b>k Total.</b> Add lines 7d and 7j. . . . .			18,276,558.	73,345.	18,203,213.	9.07

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule H (Form 990) 2011

**Part II Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total						

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

- Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .
- Enter the amount of the organization's bad debt expense . . . . .
- Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy . . . . .
- Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.

	Yes	No
1	X	
2		
3		
5		
6		
7		
9a	X	
9b	X	

**Section B. Medicare**

- Enter total revenue received from Medicare (including DSH and IME) . . . . .
- Enter Medicare allowable costs of care relating to payments on line 5 . . . . .
- Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .
- Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:  
 Cost accounting system     Cost to charge ratio     Other

**Section C. Collection Practices**

- Did the organization have a written debt collection policy during the tax year? . . . . .
- If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI . . . . .

**Part IV Management Companies and Joint Ventures (see instructions)**

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				



**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: UPPER CHESAPEAKE MEDICAL CENTER, INC.

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 7 are optional for tax year 2011)			
<b>1</b>	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8 . . . . . If "Yes," indicate what the Needs Assessment describes (check all that apply):	<b>1</b>	
<b>a</b>	<input type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input type="checkbox"/> Demographics of the community		
<b>c</b>	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input type="checkbox"/> How data was obtained		
<b>e</b>	<input type="checkbox"/> The health needs of the community		
<b>f</b>	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
<b>j</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>2</b>	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 <u>  </u> <u>  </u>		
<b>3</b>	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>3</b>	
<b>4</b>	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI . . . . .	<b>4</b>	
<b>5</b>	Did the hospital facility make its Needs Assessment widely available to the public? . . . . . If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):	<b>5</b>	
<b>a</b>	<input type="checkbox"/> Hospital facility's website		
<b>b</b>	<input type="checkbox"/> Available upon request from the hospital facility		
<b>c</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>6</b>	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
<b>a</b>	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
<b>b</b>	<input type="checkbox"/> Execution of the implementation strategy		
<b>c</b>	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
<b>d</b>	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
<b>e</b>	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
<b>f</b>	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
<b>g</b>	<input type="checkbox"/> Prioritization of health needs in its community		
<b>h</b>	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
<b>i</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>7</b>	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs . . . . .	<b>7</b>	
<b>Financial Assistance Policy</b>			
<b>8</b>	Did the hospital facility have in place during the tax year a written financial assistance policy that: Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? . . . . .	<b>8</b>	X
<b>9</b>	Used federal poverty guidelines (FPG) to determine eligibility for providing free care? . . . . . If "Yes," indicate the FPG family income limit for eligibility for free care: <u>  </u> <u>  </u> <u>  </u> % If "No," explain in Part VI the criteria the hospital facility used.	<b>9</b>	X

**Part V Facility Information (continued)** UPPER CHESAPEAKE MEDICAL CENTER, INC.

	Yes	No
<b>10</b> Used FPG to determine eligibility for providing <i>discounted care</i> ? . . . . . If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>3</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
<b>11</b> Explained the basis for calculating amounts charged to patients? . . . . . If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
<b>a</b> <input checked="" type="checkbox"/> Income level		
<b>b</b> <input checked="" type="checkbox"/> Asset level		
<b>c</b> <input checked="" type="checkbox"/> Medical indigency		
<b>d</b> <input type="checkbox"/> Insurance status		
<b>e</b> <input type="checkbox"/> Uninsured discount		
<b>f</b> <input type="checkbox"/> Medicaid/Medicare		
<b>g</b> <input checked="" type="checkbox"/> State regulation		
<b>h</b> <input type="checkbox"/> Other (describe in Part VI)		
<b>12</b> Explained the method for applying for financial assistance? . . . . .	X	
<b>13</b> Included measures to publicize the policy within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
<b>a</b> <input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
<b>b</b> <input checked="" type="checkbox"/> The policy was attached to billing invoices		
<b>c</b> <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
<b>d</b> <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
<b>e</b> <input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
<b>f</b> <input checked="" type="checkbox"/> The policy was available on request		
<b>g</b> <input type="checkbox"/> Other (describe in Part VI)		

**Billing and Collections**

<b>14</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment? . . . . .	X	
<b>15</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency		
<b>b</b> <input checked="" type="checkbox"/> Lawsuits		
<b>c</b> <input type="checkbox"/> Liens on residences		
<b>d</b> <input type="checkbox"/> Body attachments		
<b>e</b> <input checked="" type="checkbox"/> Other similar actions (describe in Part VI)		
<b>16</b> Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged:	X	
<b>a</b> <input type="checkbox"/> Reporting to credit agency		
<b>b</b> <input type="checkbox"/> Lawsuits		
<b>c</b> <input type="checkbox"/> Liens on residences		
<b>d</b> <input type="checkbox"/> Body attachments		
<b>e</b> <input checked="" type="checkbox"/> Other similar actions (describe in Part VI)		
<b>17</b> Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Notified patients of the financial assistance policy on admission		
<b>b</b> <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
<b>c</b> <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
<b>d</b> <input checked="" type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
<b>e</b> <input type="checkbox"/> Other (describe in Part VI)		

**Part V Facility Information (continued)** UPPER CHESAPEAKE MEDICAL CENTER, INC.

**Policy Relating to Emergency Medical Care**

		Yes	No
<b>18</b>	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	X	
If "No," indicate why:			
<b>a</b>	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
<b>b</b>	<input type="checkbox"/> The hospital facility's policy was not in writing		
<b>c</b>	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
<b>d</b>	<input type="checkbox"/> Other (describe in Part VI)		

**Individuals Eligible for Financial Assistance**

<b>19</b>	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
<b>a</b>	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
<b>b</b>	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
<b>c</b>	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
<b>d</b>	<input checked="" type="checkbox"/> Other (describe in Part VI)		
<b>20</b>	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? . . . . .		X
If "Yes," explain in Part VI.			
<b>21</b>	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient? . . . . .	X	
If "Yes," explain in Part VI.			

**Part V Facility Information** (continued)

**Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 1

Name and address	Type of Facility (describe)
<b>1</b> UC HEALTH LINK CLINIC 2027 PULASKI HWY, SUITE 206 HAVRE DE GRACE MD 21078	PRIMARY CARE CLINIC FOR MEDICALLY INDIGENT
<b>2</b>	
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, SECTION A, LINE 4

BAD DEBT EXPENSE

THE HOSPITAL GRANTS CREDIT TO PATIENTS, SUBSTANTIALLY ALL OF WHOM ARE LOCAL RESIDENTS. THE HOSPITAL GENERALLY DOES NOT REQUIRE COLLATERAL OR OTHER SECURITY IN EXTENDING CREDIT; HOWEVER, THE HOSPITAL ROUTINELY OBTAINS ASSIGNMENT OF (OR ARE OTHERWISE ENTITLED TO RECEIVE) PATIENTS' BENEFITS RECEIVABLE UNDER THEIR HEALTH INSURANCE PROGRAMS, PLANS OR POLICIES.

PART III, SECTION B, LINE 8

COMMUNITY BENEFIT AND SHORTFALL

THE HOSPITAL DID NOT HAVE A MEDICARE SHORTFALL.

PART III, SECTION C, LINE 9B

COLLECTION PRACTICES

IT IS THE POLICY OF UPPER CHESAPEAKE MEDICAL CENTER ("UCMC") TO ATTEMPT TO COLLECT PAYMENT FOR ALL SERVICES RENDERED TO PATIENTS IN THE MOST EFFICIENT AND PATIENT FRIENDLY MANNER. UCMC WILL FIRST ATTEMPT TO

**Part VI Supplemental Information**

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COLLECT PAYMENT FROM THE PATIENT'S INSURANCE COMPANY. IN THE EVENT THE PATIENT HAS NO INSURANCE OR LIMITED INSURANCE COVERAGE, UCMC WILL ATTEMPT TO QUALIFY THE PATIENT FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND/OR UCMC'S FINANCIAL ASSISTANCE POLICY.

PART V, LINES 15E/16E/19D/21

BILLING AND COLLECTIONS:

LINE 15E

PATIENTS WHO ARE LEFT WITH A BALANCE AFTER ALL INSURANCES HAVE BEEN PURSUED AND FINANCIAL ASSISTANCE HAS BEEN OFFERED WILL BE FORWARDED TO A COLLECTION AGENCY AS A LAST RESORT TO OBTAIN PAYMENT FROM THE PATIENT.

LINE 16E

TWO AGENCIES ARE EMPLOYED BY UCMC; EACH RECEIVING APPROXIMATELY FIFTY PERCENT OF THE ACCOUNT (BASED ON THE FIRST LETTER OF THE LAST NAME OF EACH PATIENT). ACCOUNTS PLACED WITH ONE OF THE COLLECTION AGENCIES ARE CLASSIFIED AS BAD DEBTS AND REMOVED FROM ACCOUNTS RECEIVABLE.

**Part VI Supplemental Information**

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CHARGES FOR MEDICAL CARE:

LINES 19D & 21

THE STATE OF MARYLAND HEALTH SERVICES COST REVIEW COMMISSION SETS RATES FOR ALL HOSPITALS IN THE STATE. THOSE RATES ARE APPLIED UNIFORMLY TO ALL PATIENTS. GROSS CHARGES MAY NOT BE DISCOUNTED OUTSIDE OF STATE-ACCEPTED DISCOUNTS FOR PROMPT PAYMENT AND ADVANCE FUNDING. IF A PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, A PERCENTAGE OF THE GROSS CHARGES ARE THEN WRITTEN-OFF TO CHARITY CARE.

PART VI, SUPPLEMENTAL INFORMATION

NEEDS ASSESSMENT

EVERY THREE YEARS A COMMUNITY HEALTH ASSESSMENT SURVEY/PLAN IS PERFORMED.

PART VI, SUPPLEMENTAL INFORMATION

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

THE HOSPITAL DISPLAYS SIGNS AT EVERY REGISTRATION POINT INFORMING THE PATIENTS ABOUT THE AVAILABILITY OF THE VARIOUS FINANCIAL AND MEDICAL ASSISTANCE PROGRAMS.

**Part VI Supplemental Information**

Complete this part to provide the following information.

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THE HOSPITAL OFFERS EVERY SELF-PAY PATIENT OR ANY PATIENT WHO INQUIRES  
THE FINANCIAL ASSISTANCE INFORMATIONAL PACKET AND APPLICATION. THE COVER  
SHEET FOR THE FINANCIAL ASSISTANCE PACKET ALSO INCLUDES INFORMATION ON  
OBTAINING MEDICAL ASSISTANCE.

IN ADDITION, THE HOSPITAL HAS A FINANCIAL COUNSELOR THAT VISITS THE  
SELF-PAY PATIENT IN THE EMERGENCY DEPARTMENT OR IN THE PATIENT'S ROOM TO  
DISCUSS WHAT IS AVAILABLE TO THEM.

THE HOSPITAL ALSO EMPLOYS A MEDICAL ASSISTANCE ADVOCACY COMPANY TO ASSIST  
THE HOSPITAL'S PATIENTS GET MEDICAL ASSISTANCE.

THE HOSPITAL ALSO PROVIDES INFORMATION ABOUT THE PROGRAMS IN EACH BILLING  
STATEMENT.

**Part VI Supplemental Information**

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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## PART VI, SUPPLEMENTAL INFORMATION

## COMMUNITY INFORMATION

THE SERVICE AREA OF THE UPPER CHESAPEAKE HEALTH SYSTEM, WHICH INCLUDES UPPER CHESAPEAKE MEDICAL CENTER, CONSISTS OF THE NORTHEAST PART OF MARYLAND, INCLUDING HARFORD COUNTY, WESTERN CECIL COUNTY AND PORTION OF BALTIMORE COUNTY. THIS SERVICE AREA IS LOCATED AT THE APEX OF THE CHESAPEAKE BAY AND IS SPREAD ACROSS 536 SQUARE MILES. IT CONTAINS, AMONG OTHERS, THE CITIES AND TOWNS OF HAVRE DE GRACE, ABERDEEN, BEL AIR, FALLSTON, AND EDGEWOOD. THE SERVICE AREA ENJOYS A DIVERSE ECONOMIC BASE, RANGING FROM CONCENTRATIONS IN SERVICE, MANUFACTURING, DISTRIBUTION, AND RETAIL, TO FEDERAL GOVERNMENT EMPLOYMENT. HARFORD COMMUNITY COLLEGE PROVIDES A LOCAL VENUE FOR ADVANCED EDUCATION AND HARFORD COUNTY'S PROXIMITY TO BALTIMORE GIVES IT ACCESS TO NATIONALLY RECOGNIZED UNIVERSITIES WHICH HELP PROVIDE A SKILLED WORKFORCE. THE SERVICE AREA IS SERVED BY INTERSTATE 95, AMTRAK AND FREIGHT RAIL LINES ALONG THE BUSY EAST-COAST TRANSPORTATION CORRIDOR BETWEEN NEW YORK AND WASHINGTON, DC. IN 2007, THE SERVICE AREA HAD A TOTAL POPULATION OF 276,500 PEOPLE WITH HISTORICAL ANNUAL GROWTH RATES OF APPROXIMATELY 1.8% PER YEAR. THIS

**Part VI Supplemental Information**

Complete this part to provide the following information.

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- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

GROWTH HAS BEEN CHARACTERIZED BY AN INFLUX OF YOUNG FAMILIES SEEKING SUBURBAN ENVIRONMENT IN WHICH TO LIVE AND IS COMPLEMENTED BY A GROWTH IN BUSINESSES AND OTHER SERVICES THAT FOLLOW YOUNG, MIDDLE CLASS FAMILIES. IN 2007, THE SERVICE AREA HAD AN ESTIMATED 101,930 HOUSEHOLDS WITH A MEDIAN FAMILY INCOME OF \$67,300 AND AN AVERAGE HOUSEHOLD INCOME OF \$81,000. 87% OF THE SERVICE AREA'S ADULTS OVER THE AGE OF 25 ARE HIGH SCHOOL GRADUATES OR HIGHER; 27% ACHIEVED BACHELOR'S DEGREES OR HIGHER. THE SERVICE AREA'S GROWTH AND GEOGRAPHIC LOCATION EXPLAIN ITS ABILITY TO ATTRACT MAJOR EAST-COAST DISTRIBUTION CENTER AND INDUSTRY, WHICH HAVE PROVIDED ADDITIONAL EMPLOYMENT OPPORTUNITIES IN THE SERVICE AREA. IN DECEMBER 2007, THE SERVICE AREA HAD A WORK FORCE OF APPROXIMATELY 142,829.

PLEASE SEE SCHEDULE O FOR MORE INFORMATION.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART VI, SUPPLEMENTAL INFORMATION

PROMOTION OF COMMUNITY HEALTH

UPPER CHESAPEAKE MEDICAL CENTER DID NOT HAVE COMMUNITY BUILDING

ACTIVITIES DURING THE CALENDAR YEAR ENDED DECEMBER 31, 2011.

PART VI, SUPPLEMENTAL INFORMATION

AFFILIATED HEALTH CARE SYSTEM

UPPER CHESAPEAKE MEDICAL CENTER, INC. (UCMC) IS ONE HOSPITAL IN AN "AFFILIATED HEALTH CARE SYSTEM" THAT INCLUDES A SECOND HOSPITAL, HARFORD MEMORIAL HOSPITAL, INC. (HMH), A PHYSICIAN SERVICES ORGANIZATION (UPPER CHESAPEAKE MEDICAL SERVICES, INC.), A PROPERTY HOLDING COMPANY (UPPER CHESAPEAKE PROPERTIES, INC.), A HOSPICE RESIDENCE (UPPER CHESAPEAKE RESIDENTIAL HOSPICE HOUSE, INC. & HOSPICE OF HARFORD COUNTY LLC) AND A FOR-PROFIT VENTURE WITH INVESTMENTS IN PRIVATE IMAGING SERVICES (UPPER CHESAPEAKE HEALTH VENTURES, INC.).

THE "SYSTEM" PROVIDES A BROAD RANGE OF COMMUNITY HEALTH CARE SERVICES, INCLUDING PREVENTIVE, AMBULATORY, ACUTE AND HOSPICE SERVICES, THROUGH AN

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

INTEGRATED HEALTH CARE DELIVERY SYSTEM IN HARFORD COUNTY AND PARTS OF  
BALTIMORE AND CECIL COUNTIES, IN NORTHEAST MARYLAND.

UCMC AND HMH ARE THE ONLY HOSPITALS IN HARFORD COUNTY, MARYLAND. UCMC  
OFFERS ACUTE CARE SERVICES, INCLUDING INTENSIVE CARE, EMERGENCY AND OTHER  
OUTPATIENT SERVICES, AND HAS THE ONLY ACUTE CARE MATERNITY SERVICES IN  
HARFORD COUNTY.

PART VI, SUPPLEMENTAL INFORMATION

STATE FILING OF COMMUNITY BENEFIT REPORT

THE HEALTH SERVICES COST REVIEW COMMISSION, THE STATE AGENCY THAT  
REGULATES HOSPITAL RATES IN MARYLAND, REQUIRES A COMMUNITY BENEFIT REPORT  
TO BE FILED ANNUALLY.

SUPPLEMENTAL INFORMATION

UPPER CHESAPEAKE MEDICAL CENTER EXPECTS ITS COMMUNITY HEALTH NEEDS  
ASSESSMENT AND IMPLEMENTATION PLAN TO BE COMPLETED BY THE END OF TAX YEAR  
2013 IN ACCORDANCE WITH THE AFFORDABLE CARE ACT.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IMPLEMENTATION PLAN TO BE COMPLETED BY THE END OF TAX YEAR 2013 IN  
ACCORDANCE WITH THE AFFORDABLE CARE ACT.

**SCHEDULE I  
(Form 990)**

**Grants and Other Assistance to Organizations,  
Governments, and Individuals in the United States**

OMB No. 1545-0047

**2011**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.  
▶ Attach to Form 990.

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

**Part I General Information on Grants and Assistance**

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?  Yes  No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

**Part II Grants and Other Assistance to Governments and Organizations in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Check this box if no one recipient received more than \$5,000. Part II can be duplicated if additional space is needed

1	(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)	HARFORD COMMUNITY COLLEGE 401 THOMAS RUN ROAD BEL AIR, MD 21015	52-1635738		51,258.				GENERAL SUPPORT
(2)	UPPER CHESAPEAKE MEDICAL SERVICES 520 UPPER CHESAPEAKE DRIVE	52-1501734	501(C)(3)	8,080,501.				PHY PRACTICE SUPPRT
(3)	CECIL COMMUNITY COLLEGE ONE SEAHAWK DRIVE NORTH EAST, MD 21901	23-7345298		5,481.				GENERAL SUPPORT
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table  3
- 3 Enter total number of other organizations listed in the line 1 table

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule I (Form 990) (2011)

**Part III Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.  
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

**Part IV Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

SCHEDULE I - GRANTS & OTHER ASSISTANCE

PART I, QUESTION 2 - GENERAL INFORMATION ON GRANTS AND ASSISTANCE

ALTHOUGH THE FILING ORGANIZATION DOES NOT HAVE FORMALIZED INTERNAL PROCEDYRES FOR MONITORING THE USE OF GRANT FUNDS IN THE UNITED STATES, THE FILING ORGANIZATION DOES HAVE A WRITTEN AND APPROVED CHARITABLE GIVING POLICY AND PROCEDURE. THERE IS WRITTEN CRITERIA REGARDING THE RECOMMENDATIONS FOR CONSIDERATION WHEN EVALUATING CONTRIBUTION REQUESTS SUCH AS FOLLOWS:

- (1) THAT CONTRIBUTIONS WILL BE MADE ONLY TO ORGANIZATIONS FOR PURPOSES CONSISTENT WITH UPPER CHESAPEAKE HEALTH SYSTEM'S (PARENT ENTITY) VISION

**Part III Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.  
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

**Part IV Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

AND MISSION.

(2) CONTRIBUTIONS WILL BE MADE ONLY TO NOT-FOR-PROFIT ORGANIZATIONS.

(3) CONTRIBUTIONS WILL PREFERABLY BE MADE TO ORGANIZATIONS WHICH DIRECTLY SERVE THE CITIZENS OF HARFORD AND CECIL COUNTIES.

(4) CONTRIBUTIONS WILL NOT BE GIVEN TO INDIVIDUALS (EXCLUDING SCHOLARSHIPS).

(5) CONTRIBUTIONS WILL NOT BE MADE FOR RELIGIOUS PURPOSES; HOWEVER, THERE MAY BE CONTRIBUTIONS GIVEN FOR A SPECIFIC EFFORT OR PROGRAM WITHIN A CHURCH OR RELIGIOUS FACILITY WHICH PROVIDES HEALTH-RELATED SERVICES TO THE BROADER COMMUNITY.

**Part III Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.  
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

**Part IV Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

(6) CONTRIBUTIONS WILL NOT BE MADE IN SUPPORT OF POLITICAL ADVOCACY.

(7) UPPER CHESAPEAKE HEALTH SYSTEM WILL STRIVE TO DONATE TO ORGANIZATIONS WHERE THE MAJORITY OF THE FUNDS RECEIVED ARE APPLIED DIRECTLY TO THE NEED THE ORGANIZATION IS DESIGNED TO MEET.

\*\*\* REQUESTS FOR \$5,000 AND UNDER ARE REFERRED TO THE PRESIDENT/CEO FOR REVIEW AND APPROVAL

\*\*\* REQUESTS FOR GREATER THAN \$5,000 ARE REFERRED TO THE COMMUNITY DEVELOPMENT COMMITTEE FOR DISCUSSION AND APPROVAL

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

**2011**

**Open to Public Inspection**

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- |  |  |
|--|--|
| <input type="checkbox"/> First-class or charter travel             | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions                     | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees   |
| <input type="checkbox"/> Discretionary spending account            | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

**b** If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?

**3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee              | <input checked="" type="checkbox"/> Written employment contract                     |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study                    |
| <input type="checkbox"/> Form 990 of other organizations                | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

**4** During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment? **4a**  Yes  No
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**  Yes  No
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c**  Yes  No
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

**Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.**

**5** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization? **5a**  Yes  No
- b** Any related organization? **5b**  Yes  No
- If "Yes" to line 5a or 5b, describe in Part III.

**6** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization? **6a**  Yes  No
- b** Any related organization? **6b**  Yes  No
- If "Yes" to line 6a or 6b, describe in Part III.

**7** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III **7**  Yes  No

**8** Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III **8**  Yes  No

**9** If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9**  Yes  No

	Yes	No
<b>1a</b>		
<b>1b</b>		
<b>2</b>		
<b>3</b>		
<b>4a</b>		<input checked="" type="checkbox"/>
<b>4b</b>	<input checked="" type="checkbox"/>	
<b>4c</b>		<input checked="" type="checkbox"/>
<b>5a</b>		<input checked="" type="checkbox"/>
<b>5b</b>		<input checked="" type="checkbox"/>
<b>6a</b>		<input checked="" type="checkbox"/>
<b>6b</b>		<input checked="" type="checkbox"/>
<b>7</b>		<input checked="" type="checkbox"/>
<b>8</b>		<input checked="" type="checkbox"/>
<b>9</b>		<input checked="" type="checkbox"/>

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2011

**Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

**Note.** The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 LYLE E. SHELDON	(i)	0	0	0	0	0	0
	(ii)	508,341.	243,424.	50,733.	53,200.	37,219.	892,917.
2 FAHEEM YOUNUS, MD	(i)	0	0	151,250.	0	0	151,250.
	(ii)	0	0	0	0	0	0
3 JOYCE FOX	(i)	0	0	0	0	0	0
	(ii)	168,021.	44,381.	10,744.	42,814.	1,632.	267,592.
4 JOSEPH E. HOFFMAN III	(i)	0	0	0	0	0	0
	(ii)	259,860.	109,199.	27,233.	50,750.	30,734.	477,776.
5 KENNETH D. KOZEL	(i)	0	0	0	0	0	0
	(ii)	259,655.	97,090.	37,517.	49,116.	14,123.	457,501.
6 DEAN C. KASTER	(i)	0	0	0	0	0	0
	(ii)	202,337.	72,031.	2,535.	31,674.	27,206.	335,783.
7 MARGARET M. VAUGHAN	(i)	0	0	0	0	0	0
	(ii)	269,500.	84,773.	22,361.	52,601.	24,947.	454,182.
8 E. SCOTT CONOVER	(i)	0	0	0	0	0	0
	(ii)	246,940.	89,544.	17,773.	51,503.	1,450.	407,210.
9 TONI M. SHIVERY	(i)	0	0	0	0	0	0
	(ii)	150,490.	40,019.	9,672.	36,583.	27,577.	264,341.
10 ROY PHILLIPS	(i)	202,869.	52,000.	934.	29,149.	17,329.	302,281.
	(ii)	0	0	0	0	0	0
11 OLUFUNMILAYO ONOBRAKPEY	(i)	191,423.	32,000.	279.	19,869.	906.	244,477.
	(ii)	0	0	0	0	0	0
12 TAMARA L. CALLIGARO	(i)	107,977.	11,626.	29,491.	10,135.	21,461.	180,690.
	(ii)	0	0	0	0	0	0
13 BERTHA SIMON	(i)	126,687.	11,760.	337.	26,288.	15,162.	180,234.
	(ii)	0	0	0	0	0	0
14 ANGELA M. KAITIS	(i)	117,700.	13,007.	777.	27,454.	18,173.	177,111.
	(ii)	0	0	0	0	0	0
15	(i)						
	(ii)						
16	(i)						
	(ii)						

**Part III Supplemental Information**

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SCHEDULE J, COMPENSATION INFORMATION, PART I, QUESTION 4B

AN ORGANIZATION RELATED TO THIS FILING ORGANIZATION MADE INTERNAL REVENUE

CODE SECTION 457F PLAN CONTRIBUTIONS TO THE FOLLOWING MEMBERS OF SENIOR

LEADERSHIP WHO ARE LISTED ON THIS FILING ORGANIZATION'S FORM 990, PART

VII, SECTION A, LINE 1A:

KENNETH D. KOZEL      \$13,531

E. SCOTT CONOVER      \$11,169

AN ORGANIZATION RELATED TO THIS FILING ORGANIZATION MADE SPLIT DOLLAR

LIFE INSURANCE PLAN CONTRIBUTIONS TO THE FOLLOWING MEMBERS OF SENIOR

LEADERSHIP WHO ARE LISTED ON THIS FILING ORGANIZATION'S FORM 990, PART

VII, SECTION A, LINE 1A:

LYLE E. SHELDON              \$109,924

MARGARET M. VAUGHAN      \$ 31,362

JOSEPH E. HOFFMAN III      \$ 30,462

DEAN C. KASTER              \$ 22,999

**SCHEDULE K  
(Form 990)**

**Supplemental Information on Tax-Exempt Bonds**

OMB No. 1545-0047

**2011**

**Open to Public  
Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

Department of the Treasury  
Internal Revenue Service

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

**Part I Bond Issues**

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
<b>A</b> MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091	5742172P9	08/08/2008	46,473,000.	REFINANCE EXISTING DEBT		X		X		X
<b>B</b>											
<b>C</b>											
<b>D</b>											

**Part II Proceeds**

	A		B		C		D	
<b>1</b> Amount of bonds retired . . . . .	45,465,000.							
<b>2</b> Amount of bonds legally defeased . . . . .								
<b>3</b> Total proceeds of issue . . . . .	49,220,640.							
<b>4</b> Gross proceeds in reserve funds . . . . .	3,340,680.							
<b>5</b> Capitalized interest from proceeds . . . . .								
<b>6</b> Proceeds in refunding escrows . . . . .	35,384,358.							
<b>7</b> Issuance costs from proceeds . . . . .	414,720.							
<b>8</b> Credit enhancement from proceeds . . . . .								
<b>9</b> Working capital expenditures from proceeds . . . . .								
<b>10</b> Capital expenditures from proceeds . . . . .								
<b>11</b> Other spent proceeds . . . . .								
<b>12</b> Other unspent proceeds . . . . .								
<b>13</b> Year of substantial completion . . . . .	2008							
	Yes	No	Yes	No	Yes	No	Yes	No
<b>14</b> Were the bonds issued as part of a current refunding issue? . . . . .	X							
<b>15</b> Were the bonds issued as part of an advance refunding issue? . . . . .		X						
<b>16</b> Has the final allocation of proceeds been made? . . . . .	X							
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X							

**Part III Private Business Use**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds? . . . . .		X						
<b>2</b> Are there any lease arrangements that may result in private business use of bond-financed property? . . . . .		X						

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule K (Form 990) 2011

Part III Private Business Use (Continued)

REFINANCE EXISTING DEBT

Table with 9 columns (3a-7) and 8 sub-columns (A-D, Yes/No). Contains questions about management contracts, research agreements, and financed property percentages.

Part IV Arbitrage

Table with 6 rows (1-6) and 8 sub-columns (A-D, Yes/No). Contains questions about Form 8038-T, variable rate issues, and hedge contracts.

Part V Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

THE OBLIGATED GROUP ON THE BOND ISSUES IDENTIFIED IN SCHEDULE K INCLUDE

Part III Private Business Use (Continued)

REFINANCE EXISTING DEBT

Table with 9 rows and 8 columns (A, B, C, D sub-columns). Rows include questions 3a-3d, 4, 5, 6, and 7 regarding management contracts, research agreements, and financed property percentages.

Part IV Arbitrage

Table with 10 rows and 8 columns (A, B, C, D sub-columns). Rows include questions 1, 2, 3a-3d, 4a-4d, 5, and 6 regarding Form 8038-T, variable rate issues, and hedge/GIC investments.

Part V Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

BOTH UPPER CHESAPEAKE MEDICAL CENTER, INC. (52-1253920) AND HARFORD

Part III Private Business Use (Continued)

REFINANCE EXISTING DEBT

Table with 9 rows and 8 columns (A, B, C, D sub-columns). Rows include questions 3a-3d, 4, 5, 6, and 7 regarding management contracts, research agreements, and financed property percentages.

Part IV Arbitrage

Table with 10 rows and 8 columns (A, B, C, D sub-columns). Rows include questions 1, 2, 3a-3d, 4a-4d, 5, and 6 regarding Form 8038-T, variable rate issues, hedges, and GICs.

Part V Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

MEMORIAL HOSPITAL, INC. (52-0591484). THE ALLOCATION IS AS FOLLOWS:

Part III Private Business Use (Continued)

REFINANCE EXISTING DEBT

Table with 9 rows and 8 columns (A, B, C, D sub-columns). Rows include questions 3a-3d, 4, 5, 6, and 7 regarding management contracts, research agreements, and financed property percentages.

Part IV Arbitrage

Table with 11 rows and 8 columns (A, B, C, D sub-columns). Rows include questions 1, 2, 3a-3d, 4a-4d, 5, and 6 regarding Form 8038-T, variable rate issues, hedges, and GICs.

Part V Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations [ ] Yes [ ] No

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

UPPER CHESAPEAKE MEDICAL CENTER 84%; HARFORD MEMORIAL HOSPITAL 16%.

**SCHEDULE O**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Information to Form 990 or 990-EZ**

**Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.  
▶ Attach to Form 990 or 990-EZ.**

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PART VI, SECTION A, GOVERNING BODY & MANAGEMENT, QUESTION 2

FAMILY OR BUSINESS RELATIONSHIP

LYLE E SHELDON AND JOSEPH E HOFFMAN III ARE OFFICERS IN THE SAME BUSINESS ENTITIES. THE SAME BUSINESS ENTITIES ARE THE FOR-PROFIT CORPORATIONS OR PARTNERSHIPS THAT ARE RELATED TO THIS FILING ENTITY. PLEASE SEE FORM 990, SCHEDULE R.

PART VI, SECTION A, GOVERNING BODY & MANAGEMENT, QUESTION 6

EXISTENCE OF MEMBERS

UPPER CHESAPEAKE HEALTH SYSTEM AND UNIVERSITY OF MARYLAND MEDICAL SYSTEM ARE PARTNERS IN A MARYLAND LIMITED LIABILITY COMPANY NAMED UCHS/UMMS VENTURE LLC ("VENTURE"). THE VENTURE WAS ORGANIZED FOR CHARITABLE PURPOSES TO COORDINATE ACTIVITIES OF HEALTHCARE FACILITIES AND OTHER CORPORATE BODIES WHOSE PURPOSES INCLUDE THE PROVISION OF HEALTHCARE SERVICES OR FINANCIAL ASSISTANCE TO HEALTHCARE FACILITIES IN HARFORD COUNTY, MARYLAND. VENTURE IS THE SOLE MEMBER OF THIS FILING ORGANIZATION.

PART VI, SECTION B, POLICIES, QUESTION 11B

ORGANIZATIONAL REVIEW OF FORM 990

THE BOARD OF UPPER CHESAPEAKE HEALTH SYSTEM, INC. ("HEALTH SYSTEM") HAS ASSIGNED THE EXECUTIVE COMMITTEE OF THE HEALTH SYSTEM'S BOARD TO REVIEW AND APPROVE ALL CONTENTS OF FORM 990 ON BEHALF OF THE BOARDS OF ALL HEALTH SYSTEM'S TAX-EXEMPT AFFILIATES. IN TURN, ONCE THE FORM 990 HAS

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BEEN APPROVED BY HEALTH SYSTEM'S EXECUTIVE COMMITTEE, A FINAL VERSION OF THE FORM 990 WILL BE MADE AVAILABLE TO ALL BOARD MEMBERS OF THE RESPECTIVE HEALTH SYSTEM'S TAX-EXEMPT AFFILIATES. FORMAL NOTIFICATION OF THE FINAL AND APPROVED FORM 990 FOR EACH OF THE HEALTH SYSTEM'S AFFILIATES AS WELL AS ITS AVAILABILITY WILL BE COMMUNICATED TO THE APPLICABLE BOARD MEMBERS ON OR BEFORE THE FILING OF THE FORM 990.

PART VI, SECTION B, POLICIES, QUESTION 12C

CONFLICT OF INTEREST POLICY

THE ORGANIZATION'S WRITTEN CONFLICT OF INTEREST POLICY COVERS THE FOLLOWING INDIVIDUALS: DIRECTORS, PRINCIPAL OFFICERS, AND SENIOR MANAGEMENT. FURTHERMORE, THE POLICY EXTENDS TO THE FAMILY MEMBERS (PER INTERNAL REVENUE SERVICE DEFINITION) OF SUCH DIRECTORS, PRINCIPAL OFFICERS, AND SENIOR MANAGEMENT. THE BOARD OF DIRECTORS AND ANY COMMITTEE CONSIDERING A CONTRACT, TRANSACTION OR ARRANGEMENT TO WHICH A KNOWN OR POTENTIAL CONFLICT OF INTEREST RELATES, DETERMINES WHETHER A CONFLICT EXISTS. ACTUAL CONFLICTS ARE REVIEWED BY THE CHAIRMAN OF THE BOARD. AN INDIVIDUAL WITH A KNOWN OR POTENTIAL CONFLICT OF INTEREST MUST REFRAIN FROM PARTICIPATING IN, OR ACTING ON, THE DECISION ON ANY MATTER IN WHICH A CONFLICT OF INTEREST, OR EVEN THE APPEARANCE OF SUCH A CONFLICT OF INTEREST, IS PRESENT WITH RESPECT TO SUCH INDIVIDUAL AND WILL REMOVE HIMSELF OR HERSELF FROM ANY MEETING OR DELIBERATIONS ON THE MATTER.

PART VI, SECTION B, POLICIES, QUESTION 15

PROCESS FOR DETERMINING COMPENSATION

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS APPROVES

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COMPENSATION FOR THE CHIEF EXECUTIVE OFFICER, CHIEF OPERATING OFFICER, CHIEF FINANCIAL OFFICER, AND ALL KEY EMPLOYEES. THE EXECUTIVE COMPENSATION COMMITTEE UTILIZES BUT IS NOT LIMITED TO THE FOLLOWING RESOURCES IN EVALUATING AND ESTABLISHING REASONABLE COMPENSATION: INDEPENDENT COMPENSATION CONSULTANTS, COMPENSATION SURVEYS AND COMPENSATION STUDIES. THIS ORGANIZATION AND ITS TAX-EXEMPT AFFILIATES STRIVE TO MAINTAIN AN ARM'S LENGTH RELATIONSHIP BETWEEN ITSELF AND ITS EMPLOYEES. IT IS THE GOAL OF THE EXECUTIVE COMPENSATION COMMITTEE TO ENSURE THAT TOTAL COMPENSATION (COMPENSATION AND BENEFITS) PAID TO ITS EMPLOYEES IS FAIR AND REASONABLE. FINALLY, THE PROCESS OF SETTING AND APPROVING SUCH COMPENSATION IS PERFORMED ANNUALLY BY THE BOARD'S EXECUTIVE COMPENSATION COMMITTEE.

PART VI, SECTION C, DISCLOSURE, QUESTION 19

DOCUMENTS AVAILABLE TO THE PUBLIC

THE ORGANIZATION WILL MAKE THE FOLLOWING DOCUMENTS AVAILABLE TO THE PUBLIC UPON REQUEST: ARTICLES OF INCORPORATION, BYLAWS, CONFLICT OF INTEREST POLICY, AND AUDITED FINANCIAL STATEMENTS (HARFORD MEMORIAL HOSPITAL, INC. AND UPPER CHESAPEAKE MEDICAL CENTER, INC.).

PART VIII STATEMENT OF REVENUE

LINE 2A - PROGRAM SERVICE REVENUE

GROSS PATIENT REVENUE..... \$ 260,106,771

LESS: ALLOWANCES & CHARITY POLICIES... (30,308,973)

-----

NET PATIENT REVENUE..... \$ 229,797,798

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## PART VII, SECTION A, PART I

## AVERAGE HOURS PER WEEK

THE FOLLOWING CHART DETAILS THE FILING ORGANIZATION'S BOARD OF DIRECTORS MEMBERS AND OFFICERS WHO ARE ALSO BOARD OF DIRECTORS MEMBERS AND OFFICERS OF RELATED EXEMPT ORGANIZATIONS AND THE HOURS SPENT PER WEEK ON DUTIES FOR THOSE RELATED EXEMPT ORGANIZATIONS. THE CHART DOES NOT REFLECT HOURS SPENT PER WEEK ON DUTIES FOR ANY RELATED FOR-PROFIT ENTITIES. THE HOURS REFLECTED IN PART VII, SECTION A, COLUMN B ARE ONLY THE AVERAGE HOURS PER WEEK FOR THIS FILING ORGANIZATION.

	UCF	HMH	UCMS	UCP	UCHC	UCHS	HH	UCRHH
LYLE E. SHELDON PRES/CEO	1	5	1	1	.50	40	1	.50
JOSEPH E. HOFFMAN III SR VP/CFO	1	1	1	1	1	40	-	1
JOYCE FOX VP PATIENT SERVICES/CNO	-	20	-	-	-	-	-	-
MARGARET M. VAUGHAN SR VP/CMO	-	5	1	-	-	40	-	-
KENNETH D. KOZEL SR VP/COO	1	5	1	1	1	40	-	-
DEAN C. KASTER	-	5	-	-	-	40	-	-



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## PART III, PROGRAM SERVICE ACCOMPLISHMENTS

TO PROVIDE HEALTHCARE SERVICES TO PATIENTS REGARDLESS OF THEIR ABILITY TO PAY FOR SUCH SERVICES.

FOR MORE THAN 90 YEARS, UPPER CHESAPEAKE HEALTH HAS BEEN PROVIDING COMPREHENSIVE, HIGH QUALITY HEALTH CARE. ITS TWO HOSPITALS, HARFORD MEMORIAL HOSPITAL AND UPPER CHESAPEAKE MEDICAL CENTER OFFER SOME OF THE AREA'S MOST ADVANCED INPATIENT AND OUTPATIENT SERVICES SO THAT PATIENTS CAN ENJOY THE SUPERIOR WELLNESS RESOURCES A HEALTHY LIFESTYLE NEEDS, WITHOUT LEAVING THEIR NEIGHBORHOOD. UPPER CHESAPEAKE HEALTH SYSTEM IS A COMMUNITY-BASED, NON-PROFIT HEALTH SYSTEM LOCATED IN HARFORD COUNTY, MARYLAND. OUR VISION IS BASED ON CREATING THE HEALTHIEST COMMUNITY IN MARYLAND. BUILDING ON THAT VISION, WE HAVE A STRONG COMMITMENT TO SERVICE EXCELLENCE. SO MUCH SO THAT IT HAS BECOME PART OF THE FABRIC OF THE HEALTHCARE EXPERIENCE AT UPPER CHESAPEAKE HEALTH. UPPER CHESAPEAKE HEALTH SYSTEM HAS OVER 2,500 PHYSICIANS AND HEALTHCARE PROFESSIONALS WHO ARE DELIVERING CARE FOR THE MIND, BODY AND SPIRIT IN SETTINGS FROM OFFICES, TO OUTPATIENT CENTERS, TO HOSPITALS, TO SHOPPING CENTERS, TO BUSINESSES AND HOMES. UPPER CHESAPEAKE MEDICAL CENTER IS A MEMBER OF THE UPPER CHESAPEAKE HEALTH SYSTEM. UPPER CHESAPEAKE MEDICAL CENTER IS AN ACUTE CARE, NON-PROFIT FACILITY OFFERING A FULL COMPLEMENT OF MEDICAL, DIAGNOSTIC AND EMERGENCY CARE SERVICES. THE HOSPITAL IS FULLY ACCREDITED BY THE JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO). THIS PREMIER HEALTH CARE FACILITY INCORPORATES SEVERAL TRENDS THAT REFLECT HOW HEALTH CARE IS CHANGING, INCLUDING REORIENTATION TOWARDS OUTPATIENT CARE, MORE ACUTELY ILL PATIENTS IN THE HOSPITAL AND

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FLEXIBILITY FOR GROWTH AND CHANGE TO MEET OUR COMMUNITY'S FUTURE HEALTH CARE NEEDS. LOCATED ON THE MEDICAL CAMPUS IS THE UPPER CHESAPEAKE MEDICAL CENTER WITH 194 ACUTE CARE BEDS. ADJACENT TO THE MEDICAL CENTER IS THE AMBULATORY CARE CENTER OF HARFORD COUNTY, CONTAINING PHYSICIAN OFFICES, OUTPATIENT IMAGING AND LABORATORY PROCEDURES, OUTPATIENT PRE-ASSESSMENT TESTING AND ASSESSMENT, UPPER CHESAPEAKE CARDIOVASCULAR INSTITUTE, AND THE ADMINISTRATIVE OFFICES OF UPPER CHESAPEAKE HEALTH. ALSO LOCATED NEXT TO THE MEDICAL CENTER, IS A PRE-EXISTING MEDICAL OFFICE BUILDING WITH PHYSICIAN OFFICES AND OTHER HEALTHCARE RELATED SERVICES, A PARKING GARAGE AND A SECOND MEDICAL OFFICE BUILDING WHICH INCLUDES OUTPATIENT SERVICES AND PHYSICIAN OFFICES.

HARFORD MEMORIAL AND UPPER CHESAPEAKE MEDICAL CENTER MAINTAIN CHARITY CARE PROGRAMS AND, IN ADDITION, CONDUCT MANY COMMUNITY OUTREACH AND COMMUNITY BUILDING ACTIVITIES, INCLUDING:

- COMMUNITY HEALTH EDUCATION PROGRAMS WHICH INCLUDE NEWBORN BABY CARE, SITTER SAFETY PROGRAM, INFANT CPR, INFANT SAFETY, STOP SMOKING CLASS, KIDS SAFETY CLASS, AND PRENATAL BREAST FEEDING CLASS
- SUPPORT GROUPS INCLUDING BREAST FEEDING SUPPORT, BREAST CANCER AWARENESS GROUPS, PERINATAL BEREAVEMENT, ASTHMA SUPPORT GROUP, WIDOW AND WIDOWERS SUPPORT GROUP, GRIEF SUPPORT GROUP, PROSTATE CANCER SUPPORT GROUP, AMPUTEE NETWORK, BRAIN INJURY SUPPORT GROUP, STROKE CLUB, LUPUS SUPPORT GROUP, AND OTHERS

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- HEALTH SCREENINGS INCLUDING SCREENINGS FOR OSTEOPOROSIS, CARDIAC PROBLEMS, BLOOD PRESSURE, AND OTHER ISSUES

- FREE AND MOBILE CLINICS

A NUMERICAL SUMMARY OF COMMUNITY ACTIVITIES FOR UPPER CHESAPEAKE MEDICAL CENTER IS AS FOLLOWS:

	# OF STAFF HOURS	# OF ENCOUNTERS
COMMUNITY HEALTH SERVICES	3,292	17,605
HEALTH PROFESSIONS EDUCATION	6,594	-
RESEARCH	-	20
FINANCIAL CONTRIBUTIONS	33	221
COMMUNITY BENEFIT OPERATIONS	7	-
	-----	-----
TOTAL HOSPITAL COMMUNITY BENEFIT	9,925	17,846

	DIRECT COST (\$)	INDIRECT COST (\$)
COMMUNITY HEALTH SERVICES	1,159,869	624,590
HEALTH PROFESSIONS EDUCATION	206,922	111,428
MISSION DRIVEN HEALTHCARE SVCS	3,132,501	1,686,852
RESEARCH	1,443	777
FINANCIAL CONTRIBUTIONS	70,921	38,191
COMMUNITY BENEFIT OPERATIONS	294	158
FOUNDATION FUNDED COMM. BENEFIT	109,567	59,002

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MEDICAID ASSESSMENTS	5,643,166	-
	-----	-----
TOTAL HOSPITAL COMMUNITY BENEFIT	10,324,683	2,520,997

	OFFSETTING REVENUE (\$)	NET COMMUNITY BENEFIT (\$)
COMMUNITY HEALTH SERVICES	73,345	1,711,114
HEALTH PROFESSIONS EDUCATION	2,600	315,750
MISSION DRIVEN HEALTH CARE SVCS	-	4,819,352
RESEARCH	-	2,220
FINANCIAL CONTRIBUTIONS	2,470	106,642
COMMUNITY BENEFIT OPERATIONS	-	452
CHARITY CARE	-	3,679,633
FOUNDATION FUNDED COMM. BENEFIT	-	168,569
MEDICAID ASSESSMENTS	4,687,103	956,063
	-----	-----
TOTAL HOSPITAL COMMUNITY BENEFIT	4,765,518	11,759,795

COMMUNITY OUTREACH

IN 2011, HEALTHLINK HAD APPROXIMATELY 23,060 COMMUNITY-WIDE CONTACTS THROUGH THEIR SCREENING AND EDUCATIONAL PROGRAMS, FLU VACCINATION CLINICS, SUPPORT GROUPS AND HEALTHLINK PRIMARY CARE CLINIC VISITS. APPROXIMATELY 7,400 OF THESE CONTACTS WERE FOR HEALTH SCREENINGS (BLOOD PRESSURE, BODY FAT, CHOLESTEROL, OSTEOPOROSIS, STROKE, SLEEP, DIABETES RISK ASSESSMENTS, FOOT AND EYE SCREENINGS, AND CANCER SCREENINGS). THIS

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ALSO INCLUDES 3,575 CONTACTS THAT WERE REALIZED THROUGH THE HEALTHLINK PRIMARY CARE CLINIC. OVER 2,570 INFLUENZA VACCINATIONS WERE ADMINISTERED COUNTYWIDE. COMMUNITY OUTREACH ALSO PROVIDED LOCAL BUSINESSES WITH EMPLOYEE HEALTH SCREENINGS AND VACCINATIONS TOTALING 456 ENCOUNTERS. AND MORE THAN 3,150 HARFORD COUNTY CHILDREN RECEIVED HEALTH EDUCATION FROM UPPER CHESAPEAKE COMMUNITY OUTREACH.

#### SENIOR CENTER PROGRAMS

- IN ADDITION TO COMMUNITY HEALTH HOLDING MONTHLY BLOOD PRESSURE SCREENINGS AT ALL SIX SENIOR CENTERS, A JEOPARDY HEALTH FAIR WAS HELD AT EACH CENTER. A JEOPARDY GAME WAS PLAYED ON A LARGE SCREEN FOR GROUPS OF SENIORS. THE FOCUS WAS ON GENERAL HEALTH AND WELLBEING. HEALTH SCREENINGS INCLUDING OSTEOPOROSIS, BLOOD PRESSURES AND STROKE RISK ASSESSMENTS WERE PROVIDED. THERE WERE ALSO EDUCATIONAL TABLES AS WELL AS TETANUS VACCINATIONS AVAILABLE THAT WERE PROVIDED BY COMMUNITY OUTREACH. APPROXIMATELY 250 SENIORS PARTICIPATED IN THESE EVENTS.

#### CHILDREN'S PROGRAMS

- A TOTAL OF 710 CHILDREN WERE INVOLVED WITH OUR GLO GERM PROGRAM. THIS IS A PROGRAM THAT EMPHASIZES HOW INFECTION IS SPREAD AND THE IMPORTANCE OF GOOD HAND WASHING HABITS.

- APPROXIMATELY 1,130 CHILDREN WERE EXPOSED TO OUR "KATU" (KIDS AGAINST TOBACCO USE) PROGRAM AND NEW SMOKING OUT THE TRUTH. THESE PROGRAMS TEACH CHILDREN, ADOLESCENTS, AND TEENS ABOUT THE DANGERS ASSOCIATED WITH

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TOBACCO USE. "TOXIC SOUP" IS A PROGRAM THAT ADDRESSES THE EFFECTS OF SECONDHAND SMOKE, WHICH IS A PROGRAM INCLUDED AT TIMES.

- APPROXIMATELY 1,040 CHILDREN ATTENDED OUR TEDDY BEAR CLINICS. THIS IS A PROGRAM THAT FAMILIARIZES CHILDREN WITH THE HOSPITAL EXPERIENCE.

- "BE SMART ABOUT BODY ART" WAS ALSO TAKEN OUT INTO THE COMMUNITY. IT EDUCATES TEENS ABOUT THE POTENTIAL DANGERS ASSOCIATED WITH BODY PIERCING AND TATTOOING. THIS PROGRAM HAS BEEN VERY SUCCESSFUL WITH OVER 275 TEENS BEING EDUCATED IN 2011.

- "HOW SWEET IT IS", A FAIRLY NEW PROGRAM WAS ALSO TAKEN OUT INTO THE COMMUNITY. THE PROGRAM EDUCATES CHILDREN AND ADULTS ON THE SUGAR CONTENT IN MANY OF THEIR FAVORITE DRINKS INCLUDING JUICE BOXES, SPORTS DRINKS, SODA, FLAVORED WATER, AND POPULAR COFFEE DRINKS. OVER 2,500 CHILDREN AND ADULTS WERE EXPOSED TO THIS PROGRAM.

- A NEW PROGRAM WAS DEVELOPED THIS YEAR TITLED "SUN SENSE". THIS PROGRAM EDUCATES CHILDREN, TEENS AND ADULTS ON THE HARMFUL EFFECTS OF THE SUN INCLUDING THE DANGERS OF TANNING BEDS. A SKIN ANALYZER WAS PURCHASED BY THE COMMUNITY OUTREACH. THIS MACHINE ALLOWS INDIVIDUALS TO EXAMINE THEIR OWN SKIN AND REALIZE THE IMPACT THAT THE SUN HAS HAD ON THEIR SKIN. OVER 1,235 ADULTS AND CHILDREN PARTICIPATED IN THIS PROGRAM.

- IN ADDITION TO THE ABOVE PROGRAMS, A NUTRITION PROGRAM TITLED "MISSION

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NUTRITION" WAS DEVELOPED GEARED FOR CHILDREN, TEENS AND YOUNG ADULTS, AND SENIORS. THE PROGRAM INCLUDES NEW INFORMATION REGARDING THE "MYPLATE" APPROACH, PORTION CONTROL, READING LABELS, ETC. OVER 215 ADULTS AND CHILDREN PARTICIPATED IN A NUTRITION PROGRAM.

#### NEW SCREENINGS

- IN 2011, EQUIPMENT WAS PURCHASED FOR VISION AND HEARING SCREENINGS. THIS ALLOWS COMMUNITY HEALTH TO OFFER THESE SCREENINGS TO HARFORD COUNTY PRIVATE SCHOOLS AND HOME SCHOOLERS THAT MAY NOT HAVE THE OPPORTUNITY TO BE SCREENED. HEARING SCREENINGS ARE ALSO BEING MADE AVAILABLE TO SENIORS. APPROXIMATELY 260 PEOPLE PARTICIPATED IN THESE SCREENINGS.

#### VACCINES

- COMMUNITY OUTREACH ADMINISTERED APPROXIMATELY 2,570 COMMUNITY FLU VACCINATIONS THROUGHOUT THE COUNTY IN 2011.

#### "DINING WITH DOCS" LECTURES

- IN 2011 "DINING WITH DOCS" COMMUNITY LECTURES WERE HELD AT BOTH UPPER CHESAPEAKE MEDICAL CENTER AND HARFORD MEMORIAL. A TOTAL OF 239 COMMUNITY RESIDENTS ATTENDED THE LECTURES.

#### HAVRE DE GRACE HEALTH-TACULAR

- A LARGE HEALTH FAIR WAS HELD AT THE HAVRE DE GRACE ACTIVITY CENTER. FREE FLU VACCINATIONS WERE OFFERED AS WELL AS TWENTY DIFFERENT HEALTH SCREENINGS. THESE INCLUDED BALANCE, BLOOD PRESSURE, BODY FAT COMPOSITION, CHOLESTEROL, GLUCOSE, DEXA SCANS, CAROTID ULTRASOUNDS, STROKE RISK

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ASSESSMENTS, DIABETIC EYE AND FOOT SCREENINGS, AND HEARING SCREENINGS. CANCER SCREENINGS WERE ALSO OFFERED INCLUDING PROSTATE, SKIN, ORAL AND COLORECTAL CANCER SCREENINGS. CHILDREN WERE FITTED FOR BIKE HELMETS AND PROVIDED A FREE HELMET. UCH SERVICE LINES AS WELL AS OUTSIDE VENDORS WERE REPRESENTED. THIS EVENT WOULD NOT HAVE BEEN POSSIBLE WITHOUT THE STRONG PARTNERSHIP WITH THE HC OFFICE ON AGING, PARKS AND REC AND THE BOYS AND GIRLS CLUB. OVER 380 PEOPLE ATTENDED THIS EVENT.

#### HEALTHLINK COMMUNITY WELLNESS CENTER

- IN 2011, THE HEALTHLINK COMMUNITY WELLNESS CENTER, WHICH OPERATES OUT OF THE HL MEDICAL MOBILE VAN, HAD 130 RESIDENTS PARTICIPATE IN ONE OF THE AVAILABLE HEALTH SCREENINGS OFFERED THROUGHOUT THE YEAR. THE WELLNESS CENTERS ARE OFFERED MONTHLY AT TWO DIFFERENT LOCATIONS IN THE COUNTY.

#### PRIMARY CARE CLINIC

- THE HEALTHLINK PRIMARY CARE CLINIC (PCC) PROVIDED PRIMARY CARE ON A SLIDING FEE SCALE TO LOW INCOME ADULTS AGE 19 AND ABOVE WHO ARE UNINSURED OR UNDERINSURED AND MEET SPECIFIC INCOME CRITERIA. IN 2011, THE PCC HAD APPROXIMATELY 1,315 ESTABLISHED PATIENTS AND A TOTAL OF 3,575 PATIENT ENCOUNTERS.

#### HEALTHLINK CALL CENTER

-IN 2011, OUR HEALTHLINK CALL CENTER HANDLED APPROXIMATELY 8,060 CALLS. THIS INCLUDED ALMOST 590 PHYSICIAN REFERRAL, 4,635 PHYSICIANS' RELATED

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CALLS, AND 2,335 SERVICE CALLS.

- THE "FLU HOTLINE" WAS REINSTATED TO KEEP THE COMMUNITY BETTER INFORMED ABOUT THE LOCATIONS AND TIMES THAT FLU CLINICS WERE BEING HELD THROUGHOUT THE COUNTY. AS NEW INFORMATION BECAME AVAILABLE OR CHANGED, THE RECORDING ON THE HOTLINE WAS UPDATED SO THAT RESIDENTS COULD GET ACCURATE INFORMATION.

#### SUPPORT GROUPS

- HEALTHLINK RNS FACILITATE COUNTYWIDE SUPPORT GROUPS; STROKE AND DIABETES. BOTH GROUPS MEET MONTHLY; THE STROKE GROUP MEETS AT UCMC AND THE DIABETES GROUP MEETS AT THE ABERDEEN SENIOR CENTER. TWO ADDITIONAL DIABETES SUPPORT GROUPS WERE ESTABLISHED IN 2011, ONE AT THE EDGEWOOD SENIOR CENTER AND THE SECOND AT THE MCFAUL ACTIVITY CENTER. THE STROKE GROUP AVERAGES 12 PARTICIPANTS PER MEETING (146 PER YEAR) AND THE DIABETES SUPPORT GROUPS SERVED 66 PARTICIPANTS.

#### HEALTHLINK AND COMMUNITY HEALTH IMPROVEMENT COALITIONS AND COMMITTEES

- HARFORD COUNTY SCHOOL HEALTH BOARD
- HARFORD COUNTY TOBACCO COALITION
- HARFORD COUNTY CANCER COALITION
- OFFICE ON AGING ADVISORY BOARD
- HARFORD COUNTY HOMELESS ADVISORY BOARD
- GAIN COMMITTEE
- HEALTHY HARFORD

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ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
NORTHERN CHESAPEAKE ANESTHESIA ASSOCIATE PO BOX 89 BEL AIR, MD 21014	PHYSICIAN FEES	2,507,122.
VISION CONSULTING, LLC 3325 ASPEN GROVE DRIVE, SUITE 204 FRANKLIN, TN 37067	SOFTWARE CONSULTING	1,637,782.
MEDQUIST TRANSCRIPTIONS LTD PO BOX 102467 ATLANTA, GA 30368	TRANSCRIPTION	698,014.
NCO FINANCIAL SYSTEMS, INC. PO BOX 931053 CLEVELAND, OH 44193	COLLECTIONS	479,627.
BRAIN AND SPINE SPECIALISTS PA 520 UPPER CHESAPEAKE DR., SUITE 211 BEL AIR, MD 21014	PHYSICIAN FEES	443,720.
TOTAL COMPENSATION		<u>5,766,265.</u>

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2011**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.**  
▶ **Attach to Form 990.** ▶ **See separate instructions.**

Name of the organization

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**Part I Identification of Disregarded Entities** (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) -----					
(2) -----					
(3) -----					
(4) -----					
(5) -----					
(6) -----					

**Part II Identification of Related Tax-Exempt Organizations** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) UPPER CHESAPEAKE HEALTH SYSTEMS, INC. 52-1398513 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HLTHCARE SVCS	MD	501(C)(3)	11C; III-FI	N/A		X
(2) UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 52-1398507 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	FIN SUPPORT	MD	501(C)(3)	11A	UCHS		X
(3) UPPER CHESAPEAKE MEDICAL SERVICES, INC. 52-1501734 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	PHYSICIAN SVC	MD	501(C)(3)	9	UCHS/UMMS VN		X
(4) HARFORD MEMORIAL HOSPITAL, INC. 52-0591484 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPITAL CARE	MD	501(C)(3)	3	UCHS/UMMS VN		X
(5) UPPER CHESAPEAKE PROPERTIES, INC. 52-1907237 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	TITLE HOLDING	MD	501(C)(2)	N/A	UCHS/UMMS VN		X
(6) UPPER CHESAPEAKE/ST JOE'S HOME CARE, INC 52-1229742 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPICE CARE	MD	501(C)(3)	9	UCHS/UMMS VN		X
(7) UPPER CHESAPEAKE RESIDENTIAL HOSPICE HOUSE 26-0737028 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPICE CARE	MD	501(C)(3)	7	UCHS/UMMS VN		X

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2011

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

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**2011**

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Department of the Treasury  
Internal Revenue Service

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.**  
▶ **Attach to Form 990.** ▶ **See separate instructions.**

Name of the organization

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Employer identification number

52-1253920

**Part I Identification of Disregarded Entities** (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) -----					
(2) -----					
(3) -----					
(4) -----					
(5) -----					
(6) -----					

**Part II Identification of Related Tax-Exempt Organizations** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) HEALTHY HARFORD, INC. 52-1944325 2027 PULASKI HWY, SUITE 215 HAVRE DE GRACE, MD 21078	HEALTH INIATV	MD	501(C)(3)	7	N/A		X
(2) -----							
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2011

JSA

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**Part III Identification of Related Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) UCHS/UMMS_VENT, LLC 52-2178070 520 UPPER CHESAPEAKE	MEDICAL SERVI	MD	N/A	N/A								
(2) UCHS/UMMS_REAL_ESTATE_TRUST_27 520 UPPER CHESAPEAKE DRIVE	HOLD LAND	MD	N/A	N/A								
(3) -----												
(4) -----												
(5) -----												
(6) -----												
(7) -----												

**Part IV Identification of Related Organizations Taxable as a Corporation or Trust** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) UPPER_CHESAPEAKE_HEALTH_VENTURES, INC. 52-2031264 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	MISC. SERVICE	MD	N/A	C CORP			
(2) UPPER_CHESAPEAKE_MED. OFFICE_BLDG, INC. 52-1946829 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP			
(3) UPPER_CHESAPEAKE_MGMT_SVCS_ORG, INC. 52-1946025 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	MANAGEMENT SV	MD	N/A	C CORP			
(4) UC_MEDICAL_CENTER_LAND_CONDOMINIUM, INC. 77-0674478 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP			
(5) UPPER_CHESAPEAKE_INSURANCE_COMPANY, LTD. 98-0468438 P.O. BOX 1109 KY1-1102 GRAND CAYMAN, CAYMAN ISLANDS CJ	CAPTIVE INSURANCE	CJ	N/A	LTD.			
(6) -----							
(7) -----							

Part V Transactions With Related Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35, 35a, or 36.)

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

Table with 3 columns: Description, Yes, No. Rows 1a-1r detailing transactions like receipt of interest, gifts, loans, and reimbursements.

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

Table with 4 columns: (a) Name of other organization, (b) Transaction type (a-r), (c) Amount involved, (d) Method of determining amount involved. Rows 1-6.

**Part VI** Unrelated Organizations Taxable as a Partnership (Complete if the organization answered "Yes" on Form 990, Part IV, line 37.)

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1) -----													
(2) -----													
(3) -----													
(4) -----													
(5) -----													
(6) -----													
(7) -----													
(8) -----													
(9) -----													
(10) -----													
(11) -----													
(12) -----													
(13) -----													
(14) -----													
(15) -----													
(16) -----													

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**Part VII** **Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

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